Return this form to:

61-I REVIEW FORM
Nursing Home/Waivers/ Institutions
Utah-DOH-BES 24 303 22
BES Form 1956, Jun 00

This is a review for the month of _____
ATTENTION! Failure to complete and return this form will result in a delay or termination of your _____ assistance. Complete this form and return it to the local Bureau of Eligibility Services by the ____ day of _____. You may call _____ for help with this form.

If address or phone number has changed, cross out old information and write in new address and phone number. Please provide us with proof of your new address.

Name:
Mailing Address:

Return this form to:

Your phone number _____ **Date Received:** _____

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? G Yes G No

If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. Choosing to register or declining to register to vote will not effect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, Olene S. Walker, State of Utah, 203 State Capitol Building, Salt Lake City, UT 84114.

Utah Department of Health

- O If you need help with this review form, tell us.
- O The questions refer to the person who needs the Medicaid help.
- O Answer all the questions on the form, be sure to sign and date it.
- O Provide proof of income and assets. Other proofs may be required.
- O Complete your review on time. Return the review form and proofs to the address listed above.

1. List your name in the first box. In the remaining boxes, list the names of the people who are living in your home while you are receiving nursing home or other long term care or care through a waiver program.

Name	Relationship	Social Security Medicare Number	Birth Date	Age	Marital Status
	Resident				
	Spouse				
	Dependent				
	Dependent				
	Dependent				
	Dependent				

2. Where do you live? G Hospital G Nursing Home G Group Home G Other_____

Name	Name of Institution	Admission Date	Release Date

3. Do you have or do you wish to add an authorized representative, payee, or guardian? . . . . . G Yes G No

Name	Phone #	Relationship	
Address	City	State	Zip

4. Do you, your spouses, or your dependent's expect any changes in income, resources, living arrangements or expenses? (Please explain) . . . . . G Yes G No

_____

5. Have you sold or transferred a home or any property, money, vehicle or other assets since the last application or review? . . . . . G Yes G No
If yes, please explain:_____
Date of transfer: _____ Market Value: _____

6. Do you have any of the items listed below? . . . . . G Yes G No
PLEASE PROVIDE CURRENT BANK STATEMENTS WITH THIS REVIEW

G Savings Account G Personal Checking Account G Trust Fund (TF/TM/TR)
G Credit Union Acct G Money Market Certificates G Cash
G Time Certificates G Stocks/Bonds G Other
G IRA/KEOGH/401K G Personal Needs Account

Name of Financial Institution	Account Number	Type of Account	Owner/Joint Owners	Amount

7. Are you buying or do you own or any of the types of vehicles listed below, or are you named on a vehicle belonging to someone else? . . . . . G Yes G No

G Car G SnowMobile G Motor Cycle/ATV G Other Vehicle (dune buggy,
G Truck/Van G Motor Home G Boats/Motors _____

Type of Vehicle	Make	Model	Year	Licensed Yes/No	Owner/Joint Owners	Current Value	Amount Owed

8. Are you buying or do you own or co-own any of the types of property listed below? . . . . . G Yes G No

G Home you live in (Exempt) G Camper/Trailer G Life Insurance
G Other Homes G Notes or Contracts G Funeral Plan/Burial Contract
G Time Share Condos G Satellite Dish G Burial Plans/Cemetery Plots
G Rental Property G Livestock/Horses G Life Estates/Life Leases
G Land/Mineral Rights G Tools/Equipment/Inventory G Oil or Gas Leases G Other

Type of Property	Owner/Joint Owners	Joint? Yes/No	Current Face Market Value	Current Equity/Cash Value

9. Does any person or organization give you money to pay any expenses? . . . . . G Yes G No

Name of Person/Organization	Amount	Type of Expense
	$	
	$	

10. Do you or your spouse or dependent now receive any of the income listed below? . . . . . G Yes G No
Have you, your spouse, or dependent **applied for** any of the income listed below? . . . . . G Yes G No

G Social Security G Unemployment Insurance G Interest Income
G Church Assistance G Railroad Retirement G Civil Service Annuity
G SSI G Worker's Compensation G Inheritances, Settlements, Etc.
G Child Support G Veteran's Benefits G Cash Gifts
G Alimony G Lump Sum Payments G Pension
G Rent G Other _____

Are any deductions being withheld from these benefits? (child support taxes, health insurance, overpayments, etc.)
Explain: _____ . . . . . G Yes G No

Please List Income In The Boxes Below And Provide Verification.

Name of Medicaid Recipient	Income Source	Amount
Name of Spouse	**Income Source**	**Amount**
Name of Dependent	**Income Source**	**Amount**

Name of Medicaid Recipient	Income Source	Amount
Name of Spouse	**Income Source**	**Amount**
Name of Dependent	**Income Source**	**Amount**

11. Have you or your spouse **applied for** any income\benefits **you are not** currently receiving? . . . . . **G** Yes **G** No
If yes, please explain: _____

12. Employment information: For you, spouse and dependents. Include training programs and self -employment.
PLEASE VERIFY THIS INCOME. Employer may be contacted.

NAME			NAME		
How often Paid? (circle one): Twice Month Every 2 weeks Monthly Weekly Daily Hourly Other			How often Paid? (Circle one): Twice Month Every 2 weeks Monthly Weekly Daily Hourly Other		
Name of Employer Address and Phone Number			Name of Employer Address and Phone Number		
Date Started	Average Hours Worked per Week	Day of Month/Wk Paid	Date Started	Average Hours Worked per Week	Day of Month/Wk Paid

Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.	Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.

13. Are any deductions such as child support, health insurance, overpayments, etc being withheld from the benefits listed above? . . . . . **G** Yes **G** No
If yes, please explain: _____

14. If you have a spouse or dependent at home, please mark the expenses listed below that the spouse or dependent must pay. Please list the current amount they are paying.

9 Rent	$	**9** Electricity	$
9 Mortgage	$	**9** Heating\Cooking Fuel	$
9 Second Mortgage	$	**9** Telephone	$
9 Trailer Space Lot Payment	$	**9** Water	$
9 Property Taxes (if not included in mortgage)	$	**9** Sewer\Septic Tank	$
9 Condo Fees	$	**9** Garbage	$
9 Home Insurance (if not included in mortgage)	$		

15. Is there anyone who is currently helping the spouse or dependent pay these expenses ? . . . . . **9** Yes **9** No
If yes, what is the amount the spouse or dependent must pay? _____
Agency\Individual's name:_____ Phone: _____ Amount Paid: $_____

THIRD PARTY INSURANCE INFORMATION
Î Do you or any household member have health insurance? . . . . . ‘ Yes ‘ No Insurance Company_____ Phone #_____ Premium $_____ How Often? _____ When is the next premium due?_____
Ï Have you or any household member been injured in an accident or assault? . . . . . ‘ Yes ‘ No Name of injured person _____ Date of injury _____
Ð Do you or any household member have a major medical need (including pregnancy)? . . . . . ‘ Yes ‘ No If yes, do you have insurance available that you have not enrolled in? . . . . . ‘ Yes ‘ No do you have insurance that has ended the past 60 days? . . . . . ‘ Yes ‘ No
Ñ Is any other person required to pay medical expenses for anyone in your household? . . . . . ‘ Yes ‘ No If yes, person’s name _____ Phone Number_____

AVOID PROBLEMS! You can avoid serious problems by making sure you know your rights and responsibilities and the rules for public assistance. Please read the statements below carefully. If you do not understand something, ask your worker about it. Make sure you understand everything before you sign this form.

The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I am 55 years of age or older and if: 1) I have no surviving spouse, 2) I have no surviving children under age 21, and 3) I have no surviving blind or disabled children.

Your Social Security Number, as well as other information you give us, will be subject to verification by Federal, State, and local officials. Using the State Income and Eligibility Verification System, we will make sure your household is eligible for Medicaid or other Federal assistance programs through electronic matches. Computer matching, program reviews, and audits will be done with Job Service, Immigration and Naturalization Service, Social Security, and Internal Revenue Service Records. It also includes inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about you and other household members. Computer checks will be done when you apply and after you receive assistance. Your Medicaid benefits may be reduced, denied, or terminated because of information from these sources. Knowingly providing false information may result in criminal or civil action and/or administrative claims.

I have read or had read to me the statements above. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this review are complete and correct. I am the person represented by the signature on this document. I understand that any false information on this review will result in prosecution for fraud. I understand that I may request a fair hearing if I disagree with the decision made on this review.

CLIENT sign here: Date:	Authorized Medicaid Representative:
SPOUSE OF THE CLIENT OR WITNESS: Sign here:_____ Date:_____	**G** Approved **G** Closure - Code_____ FTF **G** Yes **G** No Effective Date _____
If the applicant CANNOT write or sign name above, a Mark (X) will be used instead of a signature. One witness is required to verify and witness the applicant's mark; use Spouse Section above.	_____ Signature of Worker Date